USAID Community Care Program (Programa de Cuidados Comunitários)

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List of Acronyms

ACIDECO	Christian Interdenominational Association for Community Development
AED	Academy for Educational Development
ANEMO	National Association of Mozambican Nurses
ART	Antiretroviral Treatment
BOM	Banco Oportunidade de Moçambique
CCC	Community Care Committee
CCP	USAID Community Care Program (formerly ComCHASS)
CLC	Community Leaders Council
CSO	Civil Society Organization (community based organization)
CTARV	Care for ART
DPMAS	Provincial Directorate of Women and Social Action
DPS	Provincial Directorate of Health
DQA	Data Quality Assessment
FONGIM	Forum for International NGOs in Manica
GAAC	Community Antiretroviral Group
GAVV	Office for Attending to Victims of Violence
GTCOV	Technical Group for Orphans and Vulnerable Children
GUC	Grant Under Contract
HBC	Home Based Care (for PLHIV)
IEC	Information, Communication and Education
INGO	International Non-Government Organization
M&E	Monitoring and Evaluation
MMAS	Ministry of Women and Social Action
MOH / MISAU	Ministry of Health
MONASO	Mozambican Network of AIDS Organizations
MOPCA	Mozambique Association of Palliative Care
MOU	Memorandum of Understanding
M2M	Mother to Mother

NGO	Non Government Organization
NPCS	Provincial Núcleo to Combat AIDS
OVC	Orphans and Vulnerable Children
PES	Strategic Social Plan (Mozambican)
PH	Project HOPE
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
POA	Annual Operational Plan (of MOH)
PPPW	Pre- or Post-Partum Women
PSI	Population Services International
PSS	Psychosocial Support
REPSSI	Regional Psychosocial Support Initiative
QA / QI	Quality Assessment / Quality Improvement
SAPR	Semi Annual Progress Report
SDAE	District Services for Economic Activities
SDSMAS	District Services of Health, and Women and Social Action
SOW	Scope of Work
TO	Technical Officer
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
VS & L	Village Savings and Loan Groups
Yr1	Year 1 (of project)
Yr2	Year 2 (of project)
Yr2 Q3	Current Reporting Period, April – June 2012

EXECUTIVE SUMMARY

USAID's Community Care Program (CCP) witnessed significant growth and expansion across all levels of the project in this quarter. Project coverage increased from 48 to 51 districts, achieving 98% of CCP targeted districts. This quarter, home-based care (HBC) served 10,436 clients, now achieving 82% of the Yr2 target; care and support for orphans and vulnerable children (OVC) added 27,310 *new* OVC, achieving 62% of the Yr2 target.

Economic strengthening activities also expanded with 52 new Village Savings and Loan (VS&L) Community Facilitators, bringing the total to 92 trained to date. Sofala, Manica and Inhambane Provinces have 170 new VS&L groups. Project HOPE is implementing directly in Maputo and Cabo Delgado. Some mature groups have been able to "share out", to close a savings cycle with all members receiving back their own amount plus interest earned. Four such groups shared out an approximate total of $9,500 this quarter.

The range of services available to all target groups (PLHIV, Pre- and Post-Partum women, OVC) continued to be broadened and strengthened. Nutrition services, HBC, and support for OVC, all provided through a comprehensive family approach, show positive trends.

The Public Private Partnership within CCP between Project HOPE and Mcel for its mHealth initiative, came to fruition this quarter with the official USAID launch. The initiative is currently being piloted in Manhiça District (Maputo Province) with project clients receiving cell phone messages supporting adherence to treatment, and other reminders they choose.

CCP has completed an extensive inventory and data base of grassroots community groups involved in care and support. This will be used to strengthen community-based responses for the project target groups with long term sustainability in mind.

Both Ministry partnerships were advanced by CCP initiatives this quarter. MMAS approved the Child Protection Comportment pledge, initiated by FHI 360, for national use. MISAU supports the Integrated Caregiver initiative: HBC and OVC support in one caregiver.

Training and technical assistance for capacity building of services provision and program management is a core CCP component. This quarter, several trainings took place in all seven provinces. Data Quality Assessments served to both verify data, and, to increase M&E skills at community level. The Referral/Counter-Referral tool is now used in 19 districts and is facilitating a growing focus on links between community and clinic services.

Throughout the quarter, the consortium partners routinely exchanged valuable information as CCP moves into full implementation across the seven provinces.

The project is reaching full stride with geographical growth, new partnerships, an expanded referral system and stronger coordination. There are of course many challenges but also many members of the community are benefiting from the comprehensive approach of CCP.

OVERVIEW

USAID/Mozambique's Community Care Program, also known as Programa de Cuidados Comunitários in Portuguese, is designed to strengthen the community-based response to HIV/AIDS in seven provinces and improve the health and quality of life of people living with HIV (PLHIV), orphans and vulnerable children (OVC), and pre- or post-partum women. Working in close partnership with civil society organizations (CSOs), the Ministry of Health (MoH, or MISAU in Portuguese), the Ministry of Women and Social Action (MMAS in Portuguese), and the private sector, the Program will strengthen the government's capacity to coordinate, manage, and oversee an integrated continuum of care and support and will build the capacity of CSOs to provide comprehensive, community-based care and support services. Within five years, the Program will achieve for PLHIV, pre- or post-partum women, OVC and their families, all expected results: increased provision of family-centered, community-based HIV and care and support services and increased access to economic strengthening activities and resources for HIV-affected households.

PROJECT DESCRIPTION

The Project team, composed of FHI 360, World Relief Corporation, Africare and Project HOPE, is working to accomplish the following four objectives: 1) strengthen the organizational, technical, and leadership capabilities of CSOs and the public sector to deliver health and wrap-around services for groups targeted by the project; 2) strengthen coordination, collaboration, linkages, and partnership within and across sectors and develop efficient, innovative community-based service delivery; 3) increase the availability, accessibility, quality, and use of family-centered, age-appropriate, and gender-equitable care and support; 4) improve the capacity of vulnerable households to sustainably meet their own needs by strengthening livelihood, caregiving, and health-seeking skills. Six cross-cutting strategies are employed by the project to ensure the sustainability of project results, including: 1) community-driven approaches; 2) services integration; 3) capacity building and systems strengthening; 4) partnership and coordination; 5) performance improvement; and 6) gender-sensitive and age-appropriate interventions.

1.1 ACHIEVEMENT BY OBJECTIVES

Project Coverage

CCP has achieved 98% of project coverage (51 of 52 districts) through the end of June, in terms of geographic area. Gorongosa district in Sofala Province is the final project district undergoing the Grant Under Contract (GUC) approval process, where an originally selected CSO was replaced. During this reporting period, CSOs in Mutatara, Muanza, and Ngauma districts in Tete, Sofala, and Niassa provinces respectively, completed their SOW and Start-Up workshops, as well as the initial technical trainings on HBC/OVC, M&E, and financial management.

Implementation results have risen considerably this quarter, making strong progress toward Yr2 targets in terms of number of beneficiaries enrolled and receiving various services.

CCP Achievements to date by Service Areas and Province

Province	Yr2 Q3 Results		Total Yr2 to date		% of Achievement Yr2 to Date	
	HBC	OVC	**HBC**	**OVC**	***HBC***	***OVC***
Inhambane	1127	3722	2256	5247	*87*	*67*
Manica	1911	4299	3609	8979	*90*	*75*
Maputo	1680	1856	3088	4468	*154*	*68*
Niassa	883	2277	1600	2296	*62*	*38*
Sofala	2509	7755	3979	11469	*77*	*74*
Tete	2243	7098	3066	7116	*59*	*45*
Cabo Delgado	84	303	*84*	*303*	*21*	*25*
Total	**10,437**	**27,310**	**17,682**	**39,878**	***82%***	***62%***

This increase can be attributed to several factors:

(i) trainings and refresher courses for *activistas*;
(ii) CSOs enrolling new *activistas* to meet community needs, expanding to new areas in their districts, i.e. Marracuene in Maputo province, Dondo, Buzi, Chemba and Caia;
(iii) strategic and rigorous technical assistance (TA) to CSOs (reinforcement of identification and selection of OVC through the integrated family approach);

(iv) refresher trainings on using the M&E tools;
(v) data quality assessment (DQA); and
(vi) refresher training for *activistas* on OVC minimum package.

Conversely, the low performance in Niassa Province is due to the following factors:
(i) Nguama was not yet implementing in this reporting period; Metarica just started
(ii) CCP is currently doing data cleaning and verification to address this problem.

(iii) The CSO in Cabo Delgado began implementing later in Yr 2 than anticipated, while the target is for a full 4-quarter year of services delivery.

See Table 3 for Yr2 Q3 implementation results.

The Project HOPE provincial CSO's under their GUCs in Sofala (ADEM), Manica (Magariro) and Inhambane (Kukula), are successfully implementing the project economic strengthening activities. This quarter, these CSOs have trained 52 new VS&L Community Facilitators across Sofala, Manica and Inhambane Provinces, with 9 more for Niassa and Cabo Delgado provinces totaling 61 for the reporting period, and bringing the total to 92 trained to date. One hundred and fifty three (153) new VS&L groups in these same provinces were formed and members are now depositing their savings (in their respective VS&L groups) and taking loans either for business ventures and/or to meet social needs.

Project HOPE is carrying out direct implementation in Pemba District in Cabo Delgado Province, where they trained facilitators and established groups there. The CSO "ROADS" was approved by USAID for Niassa province districts. The CSO ADELT is awaiting donor approval for Tete province economic strengthening activities under the project.

Four VS&L groups in three districts in Maputo Province, also under Project HOPE direct implementation, have "shared out" their funds from the pilot phase totaling around US$9,500, and started a new savings and loans cycle. This activity is a very positive one, in which each VS&L group member receives their share of the group treasury comprised of one's total savings over the cycle period, plus their share of interest earned. Anecdotally, we know some members used their shares to improve their lives by rehabilitating their houses, buying mattresses and paying for school materials. Project HOPE will collect more information on this in the future.

Other relevant activity underway in all PCC sites is the collection of economic baseline data using the "Household Member Profile" to enable measuring economic progress in the members' households over time. These data are being processed and analyzed and the results will be available next quarter.

See Table 4 for VS&L details across all project areas.

In the area of Public Private Partnerships, the mHealth initiative was officially launched by USAID in June 2012 in Manhiça district (Maputo Province), where the initiative is currently being piloted. Project HOPE has partnered with **mCel**, the largest cellular phone provider in Mozambique, to establish a messaging strategy among the HBC and other project beneficiaries.

See section 4.1.3 and mHealth Success Story in Annex B-1

Africare and World Relief continue to support the CSOs they fund through GUCs and are implementing in Manica and Inhambane provinces, respectively.
See all service delivery Tables and Graphs for their details and Success Stories in Annex B.

Objective1: Strengthen the organizational, technical and leadership capacity of civil society and the public sector to deliver project services to target populations.

1.1 Capacity Building of CSOs

1.1.1 Training

After a long period of development, CCP is ready to commence its Capacity Building strategy in collaboration with former AED Capable Partners Project (CAP), now under FHI 360. In this reporting period, roles and responsibilities for both parties were finalized, with initial CSO trainings to begin in August. CCP has harmonized the earlier CSO Assessment work done by MONASO (who used five capacity categories which include the following four used by CAP plus a middle "In Consolidation" category), with the CAP strategy which uses four categories (Emerging, Growing, Consolidation, and Sustainable), for better overall implementation. Four CSOs in Maputo, Manica and Sofala Provinces will undergo CAP organizational development trainings, followed by ongoing coaching as part of their strategy. Four CCP CSOs per the three provinces equals the negotiated collaboration with CAP, per their award and model realities. CCP will gain broader district coverage, though, since some of the target CSOs are implementing in more than one district. Over time, CCP staff will assume some of the coaching themselves, as well as seeking further resources through consultancy to reach all CCP CSOs with capacity building efforts, noted in 5.5.
See Annex A2 for initial CSO Capacity Building Plan

1.1.2 Project Management

During this quarter, CCP provided feedback to CSOs of the last quarter results on all program targets, and recalculated and distributed new targets for the remainder of Year 2. During results sharing meetings, implementing CSOs were mentored to focus on planning, implementation, and monitoring of activities to achieve expected results. The newest CSOs were supported in developing their work plans, budgets and M&E plans to ensure that a clear path for implementation has been developed.

In addition, Financial Site Reviews, which are a standard FHI 360 mechanism to monitor project funds recipients, were carried out across sub-grants. CSOs learn more deeply the practices of compliance and budget management through these site reviews and the ensuing follow up mentoring visits. Each such site review results in a time sensitive well monitored action plan, and such processes form part of the CSO financial capacity building strategy. The FHI 360 finance team, both central and provincial, monitors the resultant action plans which contain due dates for compliance to the recommendations and requirements.

A new initiative to help CCP track community based personnel is the combination of providing each *activista* with a photo ID namebadge and constructing an *activista* database with names, identification numbers, dates of joining, training, etc. The central project team will use the Yr3 Workplan meeting in August, where the entire range of partners and provinces will convene to collaboratively plan the next year's implementation, to finalize "worker" uniforms.

The USAID funded Abt Associates Costing Exercise continued with visits to participating CSOs in Maputo Province. Some results will be useful in future discussions regarding the best model for CCP to use for implementation. For example, the Niassa province "umbrella" CSO model was involved in the exercise, as well as Maputo province, where the CSOs do not have a higher administrative level of costs and support.

In Inhambane province, World Relief (WR) convened all their five CSOs to evaluate how each has progressed and to exchange experiences from inception to date. WR officers also continued with regular capacity building site visits to the five CSOs covering report compilation, filing, and follow up on FHI 360 technical team recommendations from their March 2012 visit. The CSOs are also being supported on the elaboration of job descriptions for their staff, an important building block for organizational capacity.

To further build CSO capacity in project management, CCP introduced a technical assistance (TA) tracking tool, a book to register issues during TA visits to CSOs. This book holds the issues raised, recommendations, deadlines and responsibilities for follow up actions resulting from each TA visit. On subsequent TA visits, the book serves as both a record of the previous visit and the action plan for tracking progress against recommendations.

CSO capacity building is also the cornerstone of the SOW and Start-Up workshops when each new CSO comes on board. This quarter workshops were held in Ngauma, Mutarara and Marromeu districts as the prelude to commencing project implementation.

1.1.3 Monitoring & Evaluation

Across all provinces TA was provided through on-the-job trainings and mentoring to CSOs, focusing on the CCP family centered approach as an M&E entry point. The TA was comprised of general review including usage and filling of forms by *activistas*, such as: family intake form, patient register and OVC matrix, amongst others. Supervisors were also mentored on updating the data base, compiling and analyzing data, and reporting.

Data Quality Assessment (DQA) and triangulation of data (primary source compared to reported data) were carried out in 12 districts in Maputo, Manica, Sofala and Niassa provinces. This activity highlighted the difficulty that both CSO supervisors and *activistas* have in collecting and compiling data - activities carried out are not always reported. For Yr3, CCP will train CSOs and provincial M&E officers to implement monthly DQAs using a simplified 2 page tool developed by FHI 360. For the remainder of this year, DQAs will take place in Inhambane, Tete and Cabo Delgado provinces during next quarter. The CCP model for DQAs includes providing CSOs with TA on elaborating quantitative and

qualitative reports. The DQAs provide excellent opportunities for central M&E staff to evaluate progress to date and discuss possible solutions for way forward with the CSOs M&E staff.

1.1.4 HBC/OVC, PPPW, and Nutrition

During TA visits, the CSOs were refreshed on selection criteria of HBC/OVC beneficiaries and pre- and post-partum women, and minimum services guidelines including intensive and maintenance phases of support services. *Activistas* and their supervisors were also refreshed on HBC discharge criteria, to insure proper compliance.

In order to improve nutritional services referrals, the nutrition component workplan for this reporting period included the majority of the project provinces' technical teams and CSOs staff being trained in the use of Middle Upper Arm Circumference (MUAC). The MUAC is a widely used tool, including by MISAU, for identifying malnourished children (or adults) according to WHO standards, for referral to Nutritional Rehabilitation Units, where they exist. The cascade model was applied, wherein provincial technical officers were trained, along with 1-4 CSO *activista* groups, then the provincial officers trained the rest of the province's CSO teams. Inhambane Province and Pemba District teams will undergo this training next quarter, to complete this aspect across all CCP implementation areas. CCP is collaborating with UNICEF, who will provide 2,000 child MUAC tapes for CCP use and distribution. Collaboration with FANTA continues as they supported updating the MISAU nutrition guide which CCP adopted for use, and the CCP Nutrition Technical Officer actively serves on that TWG especially supporting the training curriculum, where Community Nutrition Guidelines are still in GOM approval processes.

In Sofala Province, the DPS and FHI 360 teams co-trained 11 nurse supervisors on HIV and AIDS basic facts and the CCP family centered approach, respectively.

1.2 Technical Trainings

1.2.1 Integrated HBC/OVC

This quarter, integrated HBC/OVC trainings continued to be rolled-out to the provincial sites. ANEMO and MMAS Master Trainers facilitated the trainings which used the pilot integrated curriculum for HBC and OVC caregivers. Both supervisors and *activistas* in Maputo, Tete, Niassa and Sofala provinces participated, trained as Trainers and caregivers, respectively.

See Table 1 for Yr2 Q3 Training details.

1.2.2 OVC

To address gaps identified in the last quarter on service provision to OVC, CCP provided refresher trainings to CSOs and their supervisors in three targeted provinces on the minimum standard package of services established by MMAS. These trainings also assist the *activistas* on how to use the Child Status Index (CSI) matrix to evaluate or assess OVC during intake and subsequent evaluations every three months. This type of refresher

training will continue to be carried out during the next quarter with the remaining provinces. These provide the foundation for the psychosocial support training and TA. The ToT contract with REPSSI was finalized in this reporting period, for roll out beginning in August. *See Annex A3 for PSS ToT and Activista Training Schedule*

USAID PEPFAR held a very useful set of training workshops on Child Protection Policies for both prime implementing partners and sub-grantees in this reporting period. CCP was able to mobilize participants from across all nine provinces, who will then be expected to replicate this workshop in their respective provinces and districts. CCP was able to contribute their work on developing a child protection protocol and pledge with MMAS, for use by all those working with children. The Conduct Protocol requires anyone who works with children to agree to comply with a number of behaviors that protect children from harm. *See Annex A4 for the Protocolo Comportamental (in Portuguese)*

1.2.3 Pre- and Post-Partum Women (PPPW) and Nutrition

During this quarter, 195 *activistas,* supervisors, and provincial TOs received on-the-job training on criteria for the identification, inclusion of, and support services for pre- and post-partum women. During these trainings, topics included adherence support, referral to PMTCT and other clinical services, as well as nutrition education, household gardens, nutrition demonstrations, and identification of malnutrition cases (using MUAC) for reference to HUs. These nutrition services topics are the same as those in the Integrated Caregiver curriculum which the *activistas* also transmit to the HBC clients and all project beneficiaries.

1.2.4 Village Savings & Loan Group**s**

Project HOPE provided TA training in the form of supportive supervision and mentoring visits to CSOs in project provinces with VS&L activities to strengthen VS&L Facilitators' capacities to provide assistance and support to VS&L groups. New Facilitators were trained in Manica (20), Cabo Delgado (4), Inhambane (10), Niassa (5), and Sofala (22) provinces this quarter. The formation of the groups followed, which attract both CCP beneficiaries and other community members.

1.2.5 Monitoring and Evaluation

To respond to M&E needs identified last quarter and during TA visits, CCP staff provided trainings to 379 *activistas*, supervisors and coordinators in Maputo, Manica, Niassa, and Sofala Provinces in this reporting period. Such trainings serve to improve data quality by: *activistas* correctly filling in the reporting forms, filing, analyzing and reporting on CCP targets, and were then followed by DQAs. In Tete province, the M&E trainings conducted were the initial training for 122 *activistas,* while supervisors and coordinators were trained on data flow, reporting timeline, data bases, filing, data analysis and reporting.

Table 1: Training Summary for Yr2 Q3 (Number of People Trained)

Province	Integrated Curriculum for HBC/OVC	OVC Minimum package	PPPW / Nutrition	VS&L	M&E	TOT Accreditation for OCB Supervisor	PSI Kit

	A	S	A	S	A	S	F	S	A	S		
Maputo	8	0	30	0	30	0	0	0	0	6	1	145
Manica	0	0	153	8	153	8	20	8	45	5	1	267
Tete	55	4	0	0	0	0	0	0	122	7	0	0
Cabo Delgado	0	0	0	0	0	0	4	0	0	0	0	22
Niassa	40	2	96	4	96	4	5	1	96	4	0	169
Inhambane	0	0	0	0	0	0	10	0	0	0	0	125
Sofala	45	0	95	4	95	4	22	0	90	4	0	306
Total	**148**	**6**	**374**	**16**	**374**	**16**	**61**	**9**	**353**	**26**	**2**	**1,034**

Note to the Table:
A signifies activistas trained
S signifies supervisors trained
F signifies facilitators trained

1.3 Technical Working Groups

As part of the effort to contribute to national policies and strengthen technical standards of care for targeted groups, the CCP team continued participation in technical working groups (TWGs) at the national and provincial levels. This provides a key opportunity to engage and build capacity within and between the government structures and other stakeholders. These TWGs focus on key elements of USAID Community Care Program, including HBC, OVC, Gender, QA/QI, Integration of HBC and OVC, PMTCT, Nutrition, and income generation activities for targeted groups.

1.3.1 OVC TWG

The CCP TO for OVC participated in key task force meetings (2 MMAS and 1 UNICEF) to discuss and review the draft training manual, whose focus is Support of Child Protection Committees. During the meetings, the group also discussed the draft of the behavioral protocol for interaction with OVCs (originated by FHI 360) and submitted to MMAS. The protocol has been approved by MMAS and is currently in use by several OVC implementers, demonstrating a significant FHI 360 contribution to child protection in Mozambique (Annex A4). The group also discussed coordinated trainings in psychosocial support.

1.3.2 HIV TWG

The CCP STO for HBC participated in the HIV TWG where CCP presented the results of HBC activities, and Integrated Training Curriculum (ITC) pilot. One result of the ITC seems to be increasing institutional linkages between MMAS and MISAU, and one challenge already being taken up is to integrate supervision of community level services at the district level, where the two ministries are combined as the SDSMASs. During the meeting, the TWG brainstormed a list of tools to be developed and used for follow up and evaluation of ITC.

1.3.3 PMTCT TWG

In the PMTCT TWG, two meetings were held at MISAU in Maputo. During the first, the matrix for the national plan on HIV vertical transmission was presented and discussed. The second focused on standardization of new HIV counseling and testing tools for use at the counseling and testing sites within health facilities, and mapping of partners at community levels. Participation in this TWG is important for CCP, since more and more the donors are expecting community based services to contribute to ambitious GRM PMTCT targets. The more involved CCP remains with rapidly evolving guidelines, the better equipped the project is to continuously improve the integration of community and clinical services, in the project target service areas.

1.3.4 Health Promotion TWG

The Terms of Reference (ToR) for the Health Promotion TWG have been approved by MISAU. This ToR describes the role of the TWG at national level, and of the two sub groups: Community and Clinical. CCP has presented the Referral/Counter-Referral Tool to this TWG, given the potential impact the tool and its usage can have on increasing health and well-being in communities. Through the pilot stage, referrals have been increasing alongside the ability to track them, thus strengthening the 'continuum of care' across community and clinical providers. As well, challenges have clearly arisen in the completion of referrals, as noted in 3.2.3, and 3.2.6 ahead. Generally, CCP advocates for the CSOs to pair higher literate *activistas* with lesser literate *activistas*, for internal mentoring and capacity building on using this and other forms supporting CCP activities in the field.

A follow up meeting was organized by the Community sub group to define referral networks and systems, where CCP will again present on the Referral/Counter-Referral Tool. CCP will continue to work toward total roll out of the tool to all implementing areas, in collaboration with both other FHI 360 clinical services projects in shared provinces and non-USAID supported clinical services in other provinces.

1.4 Supportive Supervision

CCP technical staff have carried out supportive supervision in a number of configurations. In partnership with ANEMO, several such visits have taken place to follow up on accredited HBC trainers, and to support the actual HBC provided by the *activistas* trained under this system. Project central technical staff have also provided supportive supervision to provincial project teams. The team is working to formalize a supportive supervision system at district level, to complement MMAS and MISAU existing systems, now that the Integrated Caregiver initiative is well received.

Objective 2: Strengthen coordination, collaboration, linkages and partnership within and across sectors to promote the development of more efficient and innovative community-based multi-sectoral responses in support of target groups

2.1 Table 2 below reflects CCP engagement with strategic partners in coordination meetings across all provinces, especially with district partners at the implementation level.

Table 2: Coordination Meetings

Province	Coordination Meetings

	DPS	DPMAS	DPA	SDSMAS	PRM	NPCS	GOV		CHASS SMT / NIASSA	Community Groups
Maputo	0	0	0	28	3	5	0		NA	3
Manica	3	2	1	0	0	1	0		0	0
Tete	2	1	0	11	3	1	0		2	0
C.Delgado	3	0	0	8	0	0	6		NA	0
Niassa	1	2	0	12	0	1	0		3	8
Inhambane	1	0	0	4	0	0	0		NA	0
Sofala	3	1	0	0	0	1	0		3	11
Total	**13**	**5**	**1**	**63**	**6**	**9**	**6**		**8**	**22**

Note to table: PRM is the Mozambique National Policy body that focuses on promoting security and preventing community violence. Additional to the table above, CCP continued to attempt linkages/partnership with other clinical partners – ICAP´s successor organization in Inhambane and ARIEL Foundation (the EGPAF successor organization) in Maputo and Cabo Delgado. See 5.7 for further details.

2.1.1 No two provinces or districts are alike, and it bears noting that coordination and collaboration take place across a diverse breadth of entities. At DPS and DPMAS (provincial) level, monthly meetings are held to review implementation and especially referral and counter referral network activities, coordination for the next month and joint supervisory visits.

2.1.2 The SDSMASs conduct their district level coordination meetings monthly, where activities implemented by CSOs are discussed. Often the Community Health Co-Management Committee leads, especially addressing *Busca activa*, the ART committee, support groups, referrals and counter referrals, and preparations for health fairs when scheduled.

2.1.3 During coordination meetings with NPCS, participants share their reports, planning of joint visits and review condom utilization. CCP fulfills its condom distribution reporting obligation through PSI, who provides the Family Health Kits used by CCP CSOs. The district level NPCS wants to receive condom distribution reports only from those who they provide condoms to in the first place, and rely on PSI's reports to avoid an overall double counting problem.

2.1.4 The district level meetings with Department of Victims of Violence (GAVV) at the PRM are a growing focus, to best realize the potential benefits to communities. The FHI 360 comprehensive referral/counter-referral tool/mechanism can be used in domestic abuse and violence situations, as well as for clinical referrals. PRM Technical Officers participated in the training on use of the referral tool in the pilot districts, and were provided a block of referral forms (the tool) to be used as needed. This two way referral opportunity allows cases found in the community to be referred to the local authorities, as well as the authorities to refer cases to the community services providers under CCP. All CCP districts will receive a supply of the referral/counter-referral forms and training on their usage, as the pilot activity is replicated in Q8. For efficiency, each CCP provincial team will take

responsibility for such trainings in their provinces, reflecting increased leadership and technical strength.

2.1.5 Meetings held with community groups focused on:

(i) reviewing existing groups and terms of reference for CCCs;
(ii) discussing types of groups and mobilizing the community to create new groups where none exist;
(iii) discussing linkages between CCCs, *activistas*, APEs[1] (where they exist), and CSOs.

2.1.6 Services Directories

The district level Services Directories arose from the Yr 1 Mapping activity. The purpose was to provide CSO *activistas*, clinical staff, and district level social services institutions with information on diverse providers in their communities for referrals to needed services. As the landscape is sure to undergo change from time to time as donor funded projects arise or close, clinical and social services expand or contract, these directories are updated on an annual basis and redistributed to users. The majority of CCP Yr 1 local Services Directories have been updated in Yr2, while Pemba District and Tete Province directories are in final stages on their first directories.

2.2 Public Private Partnership

2.2.1 The substantive development phase with CCP strategic partner Project HOPE (PH) and Mcel came to fruition with the official USAID launch of the CCP mHealth initiative in Manhiça district of Maputo Province on 4th June. Several exploratory and preparatory meetings were held with the various partners and local stakeholders, including Health Unit staff, the government of Mozambique through SDSMAS, community leaders, the CCP CSO partner ACIDECO who is hosting the mHealth pilot activity, FHI 360 and Project HOPE. The development phase included community needs assessment, collaborative designing of several menus of text messages (cell phone SMSs) for CCP beneficiaries to choose from according to their needs, installation of the Mcel software to send the reminder and information SMSs to clients and beneficiaries, and data manager and *activistas* training.
See Success Story, Annex B-1

During this reporting period, PH and Banco de Oportunidade de Moçambique (BOM) brought the Financial Literacy Manual for VS&L trainings nearly to completion, through a pilot training in June in Sofala Province. The pilot team included PH, BOM, the economic strengthening CSO for Sofala – ADEM, the district level CSO – Kupedzana, and FHI 360. Post pilot analysis and adjustments will lead to finalization of the Manual, for broad roll out during the rest of the calendar year.

PH will start their work developing an MOU with Standard Bank in the following quarter, since this activity targets the higher level economic strengthening CSOs themselves, and timed to when the VS&L groups are more mature. This relationship with Standard Bank is

[1] APEs are Agentes Polivalentes Elementares who are population-proportional community health workers within the national health system. The APE care portfolio includes Malaria treatment, treatment for diarrhea and upper respiratory infections, and general prevention.

intended to meet very long term goals. Since the bank makes loans to big agribusiness clients for example, the agreement with the bank would be for them to include in their loan contracts the condition of engaging the small holder farmers and growers who would not otherwise qualify for loan instruments.

PH will also initiate discussions in the next quarter with Millenium BIM and the USAID Development Credit Authority, building on internal steps taken to date. This partnership would explore the possibility of certain trainings which would ultimately enable people to access credit who normally cannot due to having no collateral.

Objective 3: Increase availability, accessibility, and use of family-centered, age-appropriate, and gender equitable care and support services for target groups

3.1 CCP Performance in YR2 Q3 by various analyses

3.1.1 Table 3 below shows CCP results against Yr2 targets per key activity area. Only Muanza, Gorongosa, Mutarara and Ngauma districts haven't contributed results in this quarter due to their start up time.

Project performance in Yr2 Q3 reflects a sizable increase in the total number of beneficiaries served across all implementation areas. A total of 27,310 new OVC were reached this quarter which is a 24% increase from last quarter. This results in 62% of the Yr2 target being met. Under HBC this quarter, 10,436 individuals received this service, leading to 82% of the Yr2 target being met. A greater number of pre- and post-partum women were reached than the target that has been set for Yr2. Approximately 27,483 individuals were reached with nutrition services.

Table 3: CCP Yr2 Q3 Achievement against Targets in Yr2

Indicator	Yr2 Target	SAPR	%	Yr2 Q3	%	**Yr2 Achievement to date**	**%**
New OVC	64800	12568	19	27310	42	**39878**	**62**
HBC	21600	7245	34	10436	48	**17681**	**82**
PPPW	813	1036	127	3731	459	**4767**	**586**
Nutrition	22413	8141	36	19342	86	**27483**	**123**
HBC/OVC ITC	1080	866	80	128	12	**994**	**92**
VS&L Groups	522	28	5	157	30	**185**	**35**

This increase can be understood well based on the following factors:

- Increased TA visits to project provinces and districts by TOs where mentoring and on–job-training were provided

- DQA and triangulation of data were carried out, including verification of reporting forms, refresher on M&E to *activistas*, supervisors and provincial TOs
- Refresher on minimum package of OVC services established by MMAS; identification of OVC and use of OVC matrix to evaluate their needs
- Refresher on HBC minimum package, inclusion criteria, plus review of discharge criteria which enabled *activistas* to take in new patients after some "graduated"
- TA was provided on Nutrition and identifying and enrolling PPP Women, consisting of reviewing and clarifying nutritional services which count against the indicator, as well as establishing more consistency on including PPPW receiving referrals or other services in monitoring reports.
- Involvement of community leaders in mobilizing communities to raise awareness on CCP activities and strengthening referrals/counter-referrals from community to HU
- On nutritional services, CCP achieved over 444 percent against Yr2 target in this quarter, due to the fact that the CCP family centered approach was reinforced where emphasis on nutritional services was not only targeted at direct beneficiaries but also who might be considered secondary beneficiaries; for example OVC, care givers, and other household members. Also, during TA visits, the basic nutritional service as required by the nutrition indicator that applies to CCP was reinforced, as above.
- CSOs who commenced implementation in Q6, now have performance to report this quarter (examples of Tete, Niassa, Cabo Delgado).
- In addition, such "over achievement" in both the nutrition and PPPW areas warrants attention to Yr 3 target setting. Yr 2 targets seem to have been low. It should be remembered that some individuals receive multiple services, and the PEPFAR indicators against which CCP reports are numbers of beneficiaries receiving service X, Y, or Z. For example, a beneficiary may receive HBC services, nutritional services, and referral to PMTCT.

3.1.2 Table 4 below gives a detailed per district breakdown of achievement against targets, notable that performance within provinces and across districts varies. This view removes the large differences between provincial level performance which cannot be compared due to varying numbers of target districts. This view also allows for analysis, identifying super stars, and trouble spots, since performance at district level is more comparable at the point where length of time implementing begins to equalize the outputs. For example, Cidade de Maxixe*, in Inhambane Province, with 1,789 new OVC this quarter actually have been working on improving their reporting. The World Relief and CCP central technical teams discerned that the Inhambane CSOs were considerably underreporting their service delivery, so aggressively provided TA to the CSOs and their *activistas* on correctly using the Family Enrollment and other M&E forms to better capture their efforts and those children receiving services. Barue** District in Manica Province at first appears to be extraordinarily underperforming with 0 new OVC *this quarter*. The reality is that they are already at full capacity with 2,760 OVC enrolled from previous quarters and receiving services. The CSO in Mandimba*** District in Niassa Province is quite mature and has been providing HBC and other services in their catchment area for many years already, and may be nearing exhausting that particular need there. There is need for this CSO to clarify if other parts of the district are currently underserved, to which they could shift their efforts.

Table 4: Total Numbers of Beneficiaries Reached Across all Project Provinces in Yr2 Q3 Disaggregated by Districts, Service type and Gender

District	Number **New** OVC receiving services in Yr2 Q3			Number of all HBC Clients receiving services in Yr2 Q3			Number of PPP Women	Number of all new Beneficiaries receiving nutrition Services	Total Number of VS&L Groups, and Membership Disaggregated by gender			
	M	**F**	**Total**	**M**	**F**	**Total**	**Total**	**Total**	No	M	F	Total
INHAMBANE												
Cidade De Inhambane	123	131	**254**	29	48	**77**	**22**	263	1	8	12	20
Homoine	113	131	**244**	59	167	**226**	**9**	119	5	8	8	16
Inharrime	216	229	**445**	86	244	**330**	**29**	317	4	17	75	92
Cidade De Maxixe*	846	943	**1789**	109	179	**288**	**37**	715	8	8	39	47
Morrumbene	495	495	**990**	60	146	**206**	**59**	397	4	15	63	78
Total	**1,793**	**1,929**	**3,722**	**343**	**784**	**1,127**	**156**	**18,**	**22**	**56**	**197**	**253**
MANICA												
Cidade De Chimoio	303	455	**758**	91	147	**238**	**6**	5	8	110	81	191
Barue**	0	0	**0**	51	107	**158**	**0**	0	8	83	77	160
Gondola	125	128	**253**	38	134	**172**	**7**	298	8	96	71	167
Guro	106	92	**198**	105	90	**195**	**38**	186	8	81	79	160
Machaze	136	85	**221**	60	81	**141**	**24**	269	8	33	123	156
Macossa	227	160	**387**	77	87	**164**	**23**	82	8	73	95	168
Manica	44	51	**95**	81	93	**174**	**48**	502	8	53	91	144
Mossurize	467	385	**852**	174	169	**343**	**6**	600	8	44	171	215
Sussundenga	544	611	**1155**	64	96	**160**	**626**	1119	8	47	133	180
Tambara	128	252	**380**	69	97	**166**	**53**	1724	8	92	69	161
Total	**2,080**	**2,219**	**4,299**	**810**	**1,101**	**1,911**	**831**	**3,233**	**80**	**712**	**990**	**1,702**
MAPUTO												
Boane	75	69	**144**	104	175	**279**	**32**	173	4	45	52	97
Manhica	235	214	**449**	96	173	**269**	**6**	410	0	0	0	0
Marracuene	494	555	**1049**	78	175	**253**	10	642	1	1	11	12
Matutuine	80	76	**156**	258	402	**660**	55	438	0	0	0	0
Moamba	26	32	**58**	47	172	**219**	**58**	611	2	6	43	49

Total	**910**	**946**	**1,856**	**583**	**1,097**	**1,680**	**161**	**2,274**	**7**	**52**	**106**	**158**
NIASSA												
Cuamba	346	335	**681**	139	164	**303**	**32**	116				
Mandimba***	25	34	**59**	32	78	**110**	**50**	577				
Mecanhelas	426	560	**986**	112	249	**361**	**196**	130				
Metarica	275	276	**551**	34	74	**108**	**16**	0				
Total	**1,072**	**1,205**	**2,710**	**317**	**565**	**882**	**294**	**823**	**0**	**0**	**0**	**0**
SOFALA												
Cidade Da Beira	100	112	**212**	53	85	**138**	**79**	327	3	12	33	45
Buzi	289	252	**541**	74	172	**246**	**14**	493	11	79	104	183
Caia	184	179	**363**	53	97	**150**	145	980	**4**	42	23	65
Chemba	418	402	**820**	72	109	**181**	228	601	2	12	13	25
Cheringoma	533	361	**894**	31	103	**134**	119	551	2	10	21	31
Chibabava	403	421	**824**	128	321	**449**	426	1305	7	14	73	87
Dondo	643	693	**1336**	82	284	**366**	73	785	4	25	55	80
Machanga	339	317	**656**	75	161	**236**	52	773	3	13	32	45
Maringue	453	467	**920**	43	123	**166**	267	1466	2	21	25	46
Marrumeu	249	235	**484**	63	76	**139**	61	113	12	192	118	310
Nhamatanda	351	354	**705**	118	186	**304**	235	1203	7	42	78	120
Total	**3,962**	**3,793**	**7,755**	**792**	**1,717**	**2,509**	**1,699**	**8,597**	**57**	**462**	**575**	**1,037**
TETE												
Cidade De Tete	263	293	**556**	33	43	**76**	0	0				
Cahora-Bassa	256	221	**477**	21	42	**63**	0	0				
Changara	270	221	**491**	27	72	**99**	0	0				
Maravia	214	202	**416**	48	106	**154**	4	99				
Moatize	503	389	**892**	238	536	**774**	36	150				
Tsangano	263	237	**500**	31	43	**74**	28	259				
Chiuta	172	176	**348**	126	152	**278**	127	437				
Chifunde	343	346	**689**	11	27	**38**	83	765				
Macanga	285	288	**573**	44	98	**142**	206	309				
Magoe	578	684	**1,262**	96	214	**310**	48	255				
Angónia	183	238	**421**	53	86	**139**	28	99				
Zumbo	212	261	**473**	26	70	**96**	0	0				
Total	**3,542**	**3,556**	**7,098**	**754**	**1,489**	**2,243**	**560**	**2,373**	**0**	**0**	**0**	**0**
CABO DELGADO												
Pemba	171	132	**303**	32	52	**84**	30	231	4	3	60	63
Total All Province	**13,530**	**13,780**	**27,310**	**3,631**	**6,805**	**10,436**	**3,731**	**19,342**	**170**	**1,285**	**1,928**	**3,213**

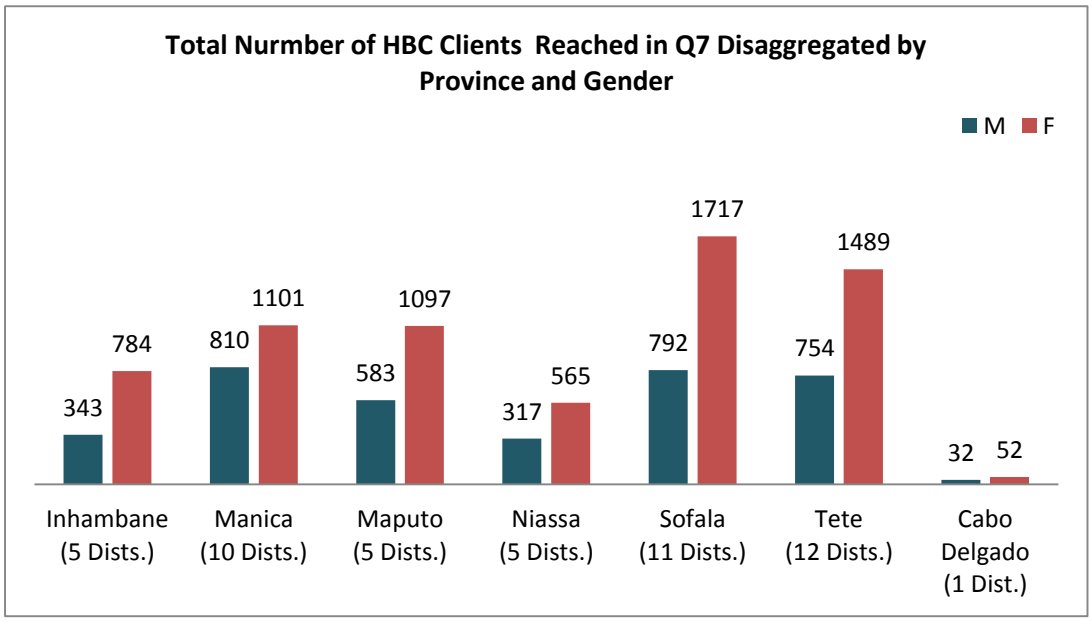
Overall among OVC, 13,530 (49.6%) males received services compared to 13,780 females (50.5%), almost equal. Contrary to OVC data, HBC data shows that fewer males, 3,631

(35%), received services compared to females, 6,805 (66%) almost a 1 to 2 ratio. Interestingly, women comprise 60% of VS&L group members, while men comprise 40%. Among PPPW and all those receiving nutritional services, service delivery lows likely reflect variations in CSO and *activista* uptake of processes and reporting; ongoing TA prioritizes such needs.

The explosive growth in numbers of Village Savings and Loan (VS&L) groups and participants in Yr2 Q3, from seven groups operating last quarter only in Maputo Province **to 170 groups now**, owes to the Project HOPE CSOs commencing their activities in Inhambane, Manica, and Sofala Provinces. PH implements directly in Maputo Province and Pemba District (Cabo Delgado) and when USAID approval comes forth, the CSO selected for Tete will be able to make a big contribution in that province.

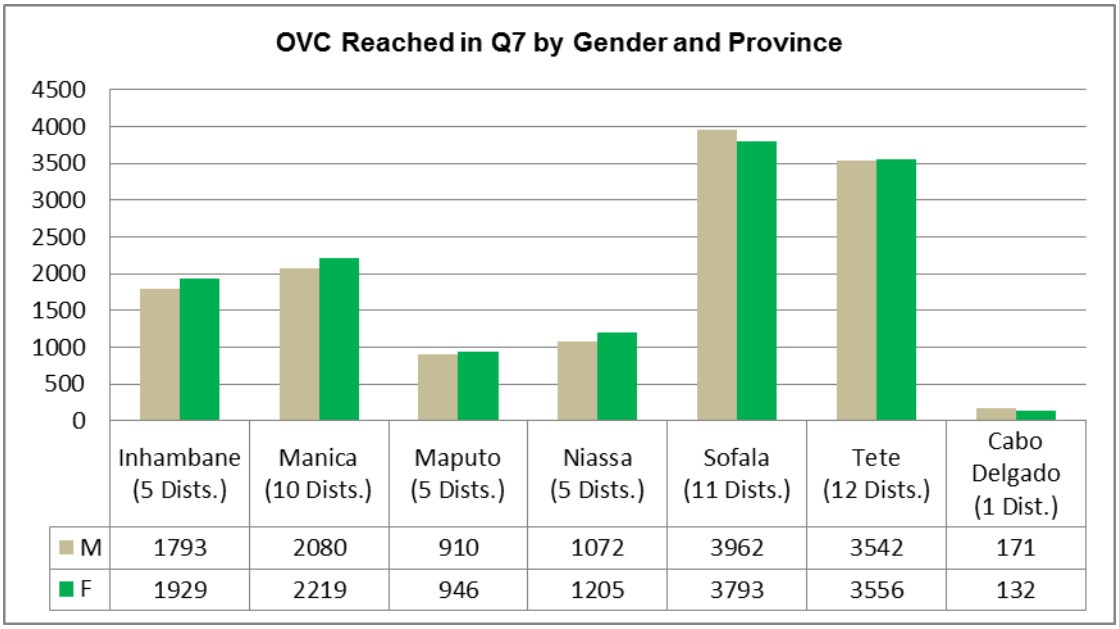
3.1.2 Province based Performance

Graph 1: Number of Clients Reached with **HBC** in Yr2 Q3, by Gender and Province



See Annex A5 for HBC clients by Outcomes

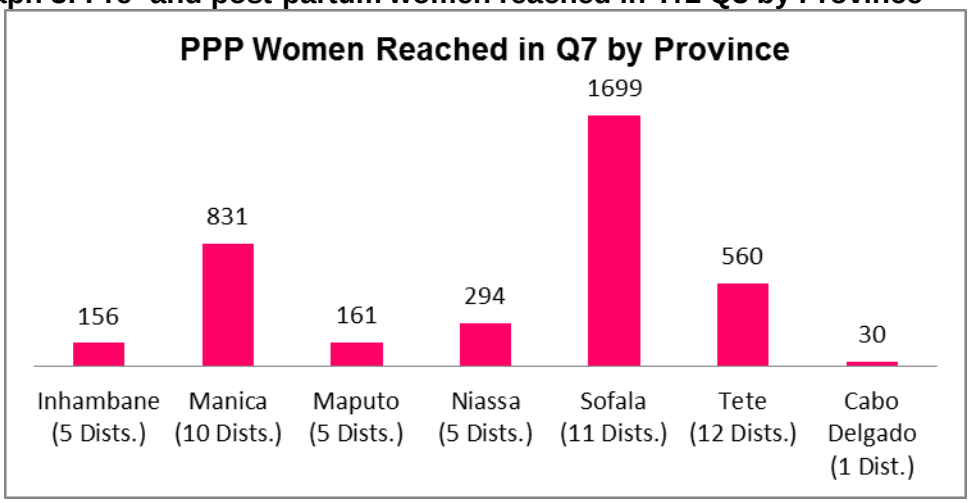
Graph 2: OVC Reached in Yr2 Q3 by Gender and Province



	Inhambane (5 Dists.)	Manica (10 Dists.)	Maputo (5 Dists.)	Niassa (5 Dists.)	Sofala (11 Dists.)	Tete (12 Dists.)	Cabo Delgado (1 Dist.)
M	1793	2080	910	1072	3962	3542	171
F	1929	2219	946	1205	3793	3556	132

See Annex A6 for OVC service delivery by Type of Service

Graph 3: Pre- and post-partum women reached in Yr2 Q3 by Province

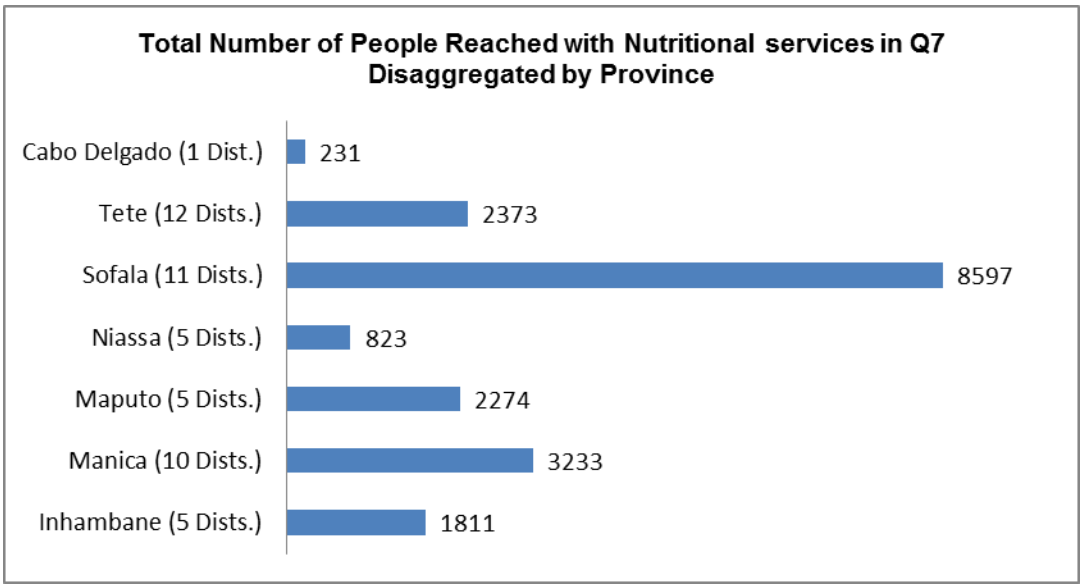


See Annex A7 for PPPW reached by district

Overall, "reaching" pre- and post-partum women refers to all the services they receive in CCP. These include palestras (health talks), referral to PMTCT, the same array of nutrition services as the other project target groups, adherence support and well being counseling through home visit follow ups.

In both Graphs 3 above and 4 below, Sofala Province outperformed in both areas of reaching pre- and post-partum women and providing nutritional services in this quarter. Their data have been re-checked and found to be solid. Both the central technical team and the provincial team made an extraordinary push in Yr2 Q3 to identify target groups, provide nutritional services, and report correctly.

Graph 4: Number of Beneficiaries receiving **Nutritional Services** in Yr2 Q3, by Province



3.1.3 Adherence Support is a continuous process of counseling PLHIV by *activistas* to maintain their treatment and ensure they take their medications properly. The most common adherence categories for HBC clients are 1) keeping regular clinic review appointments, known as "control"; 2) ARVs for HIV; and 3) treatment for TB. Pediatric cases being followed through CCP represent a small proportion of adherence support activities. Females outnumber males in all categories and across age groups.

Table 5: **Adherence Support provided to HBC clients in Yr2 Q3**

Description of Adherence Support	# of clients aged 0 to 14 years old		# of clients 15 years and older	
	M	F	M	F
# of Clients for Control at HU	202	201	956	2163
# of Clients on ARV Treatment	128	157	730	1851
# of clients on TB Treatment	11	57	237	331
Total	**341**	**415**	**1,923**	**4,345**

3.1.4 Busca Activa is the Portuguese phrase meaning active case finding, of people who are on ARV treatment for HIV but have become Lost to Follow Up (LTFU). This activity is pursued jointly by community- and clinic-based individuals, in this case the CCP *activistas,* and clinic counterparts often known as case managers. A clinic will compile its list of

treatment defaulters, those who meet the LTFU clinical criteria of number of "control" visits missed, or length of time since a PLHIV has not returned for ARVs refills. Often the Co-Management team meetings, comprised of clinical and community providers, serves as the hub of collaboration. Community *activistas*, given their close knowledge of their communities, then assist the clinic staff with searching for the defaulters on the clinic list. The summary table below shows the results for this reporting period.

Table 6: **Summary Busca Activa Disaggregated by Province and Gender in Yr2 Q3**

	# of PLHIV on Lists given to CSOs for Busca Activa		# of Defaulters Identified and Referred to their Health Unit		# of Defaulters fully returned to their Health Unit and ARVs regimen	
Province	**M**	**F**	**M**	**F**	**M**	**F**
Inhambane	99	182	59	108	53	87
Manica	125	240	58	97	49	64
Maputo	50	99	15	41	15	38
Niassa	79	174	58	144	55	118
Sofala	211	414	154	265	141	244
Tete	210	178	56	96	55	81
C. Delgado	98	111	2	16	2	5
Total	**872**	**1,398**	**402**	**767**	**370**	**637**
% Disaggregated by Gender			46	55	42	46
Total M/F	**2,270**		**1,169**		**1,007**	
% Identified and Referred (from list)	51					
% Return to HU and ARVs (from list)	44					

See Annex A8 for Busca Activa disaggregated by District

- Notes to table: Full return of defaulters under CCP would be the same as for the clinical partners, meaning they are returned to treatment and or other clinical care services at the health units. Main reasons for default from CCP *activistas'* experience are mostly distances and lack of basic food. While all implementers contributing to busca activa – including public health facilities, externally funded projects, and communities – can feel proud of successes in returning defaulters to their treatment regimens, some defaulters will remain unfound. This seems due to giving incorrect names and addresses at the HU in the first place, having moved from the area to their farms, or even having relocated to other provinces for economic reasons.

3.2 Other Activities accomplished within Objective 3

3.2.1 CCP central team and USAID carried out a joint site visit to Pemba district to provide technical support to the CSO Kaeria there prior to rolling out the community-based services.

3.2.2 CCP subgrantees (the CSO implementers) participated in 138 district level coordination and partner meetings. ANEMO, DPS, CHASS SMT, CCP staff and Provincial Leads in Manica, Sofala, Inhambane and Niassa Provinces carried out five joint supervisory visits. These visits are important for partnership and cross-stakeholder collaboration, and serve to:

i) evaluate the quality of services provided by *activistas* and trainers
ii) identify issues/problems that *activistas* are facing
iii) provide TA to CSOs; and
iv) reinforce collaboration with Health Units regarding referrals and counter-referrals.

3.2.3 The CCP referral and counter-referral system to and between clinical, social, and community services at district level is improving gradually. This can be attributed to regular meetings held at various levels with DPS, SDSMAS, CCCs and other partners. Changing an entrenched mindset from 'sending someone to the clinic is a referral' to 'a *complete* referral is when the caregiver who initiated the referral has evidence that the referred client reached the clinic or other referral destination, and received the intended service' is a challenge. For example, the CSO teams are facing confidentiality and information issues. SMI clinic nurses are reluctant to fill in the referral completion part of the referral form as they do not want to disclose any information that could be inferred as breaking a patient's confidentiality. Pre- and post-partum women are most definitely being referred to the SMI clinics at the Health Units but we currently are not able to know how many go on PMTCT. To overcome, CCP remains in continuing discussions with clinical partners to try to progress on this situation that faces everyone. Generally CCP can say that relationships of trust do get created between PPPW and *activistas*, and correct names may be known at that level but it still does not always carry through to PPPW referral consults to the SMI clinics for PMTCT services. There is a "cardenneta da mulher" with one's national identification, but uptake of its use has been inconsistent. More openness about referrals may work for HBC clients who are already in treatment because they may not be struggling with stigma issues as much and might be less concerned about confidentiality. CCP will continue to make efforts to overcome this issue. (See Table 6 below)

3.2.4 CCP CSOs are constantly being reminded of the importance of the various Community Care Committees (CCCs) in implementing their activities. They must work together to build the strength and capacity of the whole community to achieve the kind of continuum of care envisioned for true community based services. See Table 7 below for details on other activities implemented in Yr2 Q3.

Table 7: Other Activities implemented during Yr2 Q3

Activity	# of Referrals		# of Completed Referrals		Numbers reached per category	
	M	F	M	F		
Referrals of HBC clients	991	1,732	383	698		

Referrals of OVC to services	610	730	457	543									
Referrals of PPP women to PMTCT	406		?										
Referrals to Nutritional Services	7,024		3,664										
# of CSOs Coordination meetings with SDSMASs						128							
# of TWG meetings with DPS (provincial level)								44					
# of Children Clubs established										20			
Multi-level Joint Supervisory visits													5

Note to the table: Referral is considered completed when the beneficiary goes to **and** receives services referred to, and then returns to the *activista* with the response.
OVC referrals are usually to nutritional rehabilitation centers.
As discussed in previous reports, the counter –referral concept (which attains the completed referral) needs continuous refreshing at implementation level. Those at the receiving end of the referral (service providers) may not have information on the need to counter refer (complete the referral), and the frequent change of HU staffing plus their workload are also likely factors. We believe that using the FHI 360 developed Tool contributes to completed referrals, since the form itself contains a feedback, sign off, section.

3.2.5 Community Mobilization

CCP has concluded the mapping of CCCs located in 38 districts of 5 Provinces, with the exception of Tete Province and Pemba District in Cabo Delgado. Types of CCCs identified are: Community Health Committees, Community Leaders Councils, Child Protection Committees, Co-Management Committee*, Auditing Committee, MCH Death and Community Management Committees, and Humanization Committees.* The Community Child Protection Committees (CCPCs) warrant special focus. It is planned that they would be represented in the PSS *activistas* trainings which begin next quarter, and further planned for Yr3 that all CCPCs would also be trained in PSS to empower them in their target group area.

Support groups were also identified such as Mothers to Mothers groups (M2M), PLHIV support groups, GAACs and Childrens Clubs. APEs were also identified (although they are population based Community Health Workers and not groups) since coordinating community care and referrals and counter-referrals with them is hugely important.

Provincial teams will engage with the implementing CSOs next quarter to start developing CCC strengthening activities, leading to a scope of work at CSO level. This activity will serve the dual purpose of also building the capacity at the CSO level to support other local entities, and further build toward community sustainability of activities which fulfill the needs of families and especially vulnerable children in the communities. This will go hand in hand with community involvement plans to absorb the gender mainstreaming strategy just completed.
See Annex A9 for CCCs Inventory

3.2.6 In striving to improve QA/QI, the FHI 360 Referral/Counter-Referral initiative pilot has concluded and the comprehensive two-way referral tool is now used in 19 districts across Maputo, Sofala, Manica and Niassa Provinces. A training accompanies a shipment of the referral tools, which will further roll out to other CCP provinces nesxt quarter. CCP is not only referring beneficiaries to various services but is also receiving referrals from clinical and community partners. For example, Sussundenga referred **297** to Social Action for such services as housing, obtaining Poverty Certificates, or further referral to INAS for food support. Practicing the Counter-Referral, Social Action referred **411** to the CCP CSO for families requiring *activista* follow up visits. In other examples, Manhiça and Chimoio Districts referred 61 and 15 beneficiaries respectively to HUs, and in turn the Manhiça CSO received 11 counter-referrals from the HU specifically for HBC, and the SDSMAS in Chimoio counter-referred 42 to the CSO for *activista* family care follow up. In the area of referring OVC for housing, true community collaboration takes place, wherein *activistas* coordinate with community leaders to sensitize the community to rehabilitate OVC houses, and in some cases, *activistas* do the rehabilitation themselves. (See Table 6 below)

Table 6: CCP Referral and Counter-Referral Activity in Yr2 Q3

Sites		**Referrals made**				**Referrals Completed**				**Counter-Referrals (Referrals received)**	
Province	**District**	HU	Social Action	Other CSOs	Total Refer	HU	Social Action	Other CSOs	Total Completed refer	Social Action	HU
Maputo	Manhiça	61	0	0	61	35	0	0	35	0	11
	Total	61	0	0	61	35	0	0	35	0	0
Sofala	Beira	188	46	2	236	167	4	0	171	0	0
	Dondo	119	236	38	393	104	171	38	313	0	0
	Nhamatanda	520	345	60	925	123	48	32	203	0	0
	Cheringoma	242	506	194	942	193	363	100	656	0	0
	Total	1,069	1133	294	2496	587	586	170	1,343	0	11
Manica	Machaze	235	6	0	241	48	0	0	48	0	0
	Mossurize	382	18	0	400	0	0	0	0	0	0
	Sussundenga	300	297	0	597	142	297	0	439	411	0

	Gondola	15	0	0	15	0	0	0	0	0	0
	Chimoio	15	17	0	32	15	0	0	57	42	0
	Manica	156	20	0	176	74	12	0	86	0	0
	Barué	174	131	0	305	11	131	0	142	0	0
	Macossa	217	83	0	300	4	83	0	87	67	0
	Guru	423	311	0	734	199	248	0	447	0	0
	Tambara	277	253	0	530	94	198	0	292	0	0
	Total	2,194	1,136	0	3,330	629	969	0	1,598	478	0
Niassa	Mandimba	53	0	15	68	52	0	0	52	0	0
	Metarica	72	198	0	270	0	0	0	0	0	0
	Cuamba	6	0	0	6	2	0	0	2	0	0
	Mecanhelas	451	233	0	684	0	0	0	0	0	0
	Total	582	431	15	1028	54	0	0	54	0	0
Total		**3,906**	**2,700**	**309**	**6,915**	**1,305**	**1,555**	**170**	**3,030**	**478**	**11**

Notes to the table:
Referral Made: CSO activistas refer CCP beneficiaries to clinical and social services
Referral Completed: those referred by activistas receive services and return with the response
Counter Referral: Referral initiated by clinical or social services providers to CCP CSOs' activista support.

Manhiça* district is the pilot site for the FHI 360 QA/QI strategy, which CCP chose to elaborate using the Referral/Counter-Referral tool, is still in progress according to schedule. Beira** and Dondo** districts were second phase pilot sites for the Referral/Counter-Referral tool.
The Referral/Counter-Referral tool and training on usage has been rolled out to the rest of the districts in the table.

Objective 4: Improve capacity of vulnerable households to meet their own needs in sustainable ways by strengthening their livelihoods, care taking and health seeking skills.

4.1 Village Savings and Loan (VS&L)

4.1.1 In this quarter, 170 new VS&L groups were established by economic strengthening CSO's in Inhambane, Manica, and Sofala Provinces by the CSOs Kukula, Magariro, and ADEM, respectively, who are subcontracted by Project HOPE. These groups provide saving and lending services to 3,213 community members, (1,928 women, 1,285 men over all).
See Table 4 above for VS&L Group member gender and district breakdown

PH carries out direct implementation themselves of the economic strengthening activities in Cabo Delgado and Maputo Provinces. In this quarter, four of the 170 new VS&L groups were established in Cabo Delgado after four new Community Facilitators were trained (Table 1) and have 63 members out of which, 60 are females and the remaining three are

males. In Maputo Province, seven additional groups were formed this quarter, with 158 new members (52 males and 106 females). Twenty eight (28) VS&L groups established in previous quarters have increased their membership base slightly from 603 to 608. Of these early VS&L groups, four have been in existence long enough to complete their first savings cycle and successfully "shared out" the savings, totaling 273,100 Metacais (around US$9,500, depending on exchange rate used). In this process, all members received their individual savings amounts plus the interest earned and have initiated new savings and loans cycles.

4.1.2 The economic strengthening CSOs have successfully implemented all the activities in their SOWs and Monitoring Plans during this reporting period.

Amplifying on the Training Summary in Table 1 earlier in this report, 52 new VS&L *Community Facilitators* were trained (22 in Sofala, and 20 in Manica and 10 in Inhambane Provinces). This brings to a total of 92 *Community Facilitators* trained to date (with the 4 also above). 153 new VS&L groups (57 in Sofala, 80 in Manica and 22 in Inhambane) were formed and members are now depositing their savings in their respective VS&L groups and taking loans either for business ventures and/or to meet social needs.

In Niassa province, after a long search, an economic strengthening CSO (ROADS) was approved by USAID to start implementation across all 5 project districts. The economic strengthening CSO identified for Tete Province, named Agencia de Desenvolvimento Local de Tete (ADELT) is awaiting donor approval.

4.1.3 Partnership with Mcel on the mHealth initiative, as mentioned above, is fully rolled out for a six-month pilot phase, based with the CCP CSO named ACIDECO in Manhiça District of Maputo Province. At the end of this reporting period, a total of 62 clients are receiving "SMSs", or text messages on their cell phones, reminding them either to take medications (thus providing adherence support), or to keep appointments (supporting retention), or attend relevant support meetings. Project *activistas* work with each CCP beneficiary to select the messages most relevant to their needs.

A process evaluation is planned to learn from the pilot, and its protocol is currently being reviewed by Human Subjects Review Committees in FHI 360 US and Mozambique. The next phase includes rolling out to a selected district in the remaining CCP Provinces.

4.1.4 Other Public Private Partnerships
The provincial teams will take up the search for PPPs in their own areas, to be discussed thoroughly at the Yr 3 Workplan meetings.

4.2 Self Care

4.2.1 Family member caregivers of HBC clients have benefited from skills transfer related to general home care of their sick relatives such as hygiene, nutrition education, and living positively. This skills transfer is a normal part of the HBC package of services provided.

4.2.1 PSI Kits

In this reporting period, PSI distributed 8,000 OVC family health kits and 4,000 adult PLHIV kits to CSOs in Inhambane (5 districts), Sofala (3 districts), Cabo Delgado (1 district) and Maputo (5 districts) Provinces for distribution to their beneficiaries.

5. Challenges and Ways to Overcome Challenges

5.1 PLHIV

Challenge: *Busca activa* is complicated by the fact that some patients give false names and addresses at the health facility. CCP knows that the CHASS Niassa project faces this same issue.

To overcome: As this may be a system wide challenge, perhaps a system level action to address it is needed. Perhaps patients at ARV and all clinics could be required to provide their unique identity number with their name, when receiving services?

5.2 Pre- and post-partum Women

Challenge: Difficulty in confirming that a complete referral of pre/post-partum women (PPPW) to PMTCT services has been made. As mentioned above, this is more a social (breaching confidentiality) issue than a paperwork or mechanism issue.

To overcome: CSOs and their *activistas* expand their sphere of collaboration to include TBAs to build an even more unified local support network, and more trust among PPPW.

5.3 OVC

Challenge: Limited availability of social support services in the community for OVC. *Activistas* are able to assess the needs of OVC but cannot always provide a referral to a service that can fulfill the needs, especially in the area of nutrition.

To overcome: To increase community based solutions, the CSOs could facilitate collaboration between agricultural extension services and community leaders such as traditional chiefs, who control land use, for the purpose of developing community gardens to address some of the unmet need.

5.4 M&E

Challenge: Many *activistas* feel they have too many forms to fill out in reporting on the services they provide.

To overcome: In preparing for Year 3 workplan development, CCP is reviewing the M&E reporting tools and aims to reduce, where possible, the number and/or complexity of reporting tools and mechanisms without losing program or data quality.

5.5 Capacity Building

Challenge: CAP activities will not extend to all provinces and districts covered by CCP.

To overcome: CCP has issued a tender for other implementers who could carry out similar activities to complement the CAP activities, as well as re-orienting some project staff across the provincial teams to fill some of the geographic gaps.

5.6 Contract Management

Challenge: Occasional very long donor approval timeframes or burdensome processes.
To overcome: CCP leaders together with the COR meet with the mission Contracting Office to discuss support for CCP implementation needs.

5.7 Linking with other USG funded providers

Challenge: In CCP provinces where CDC funded partners support local clinics, there seems to be misunderstanding on the clinic side about working together across the community-clinical spectrum, despite efforts to collaborate.
To overcome: CCP will invite both ARIEL Foundation (formerly implemented by EGPAF) and I-CAP staff to the Year 3 Workplan workshop to better cement collaboration.

5.8 Provincial level funding requests

Challenge: Some DPSs and DPMASs submit unsupportable requests for funding assistance.
To overcome: CCP has established a protocol for CHASS SMT provinces, e.g., whereby DPS requests are first communicated to the Abt Associates team to check for existing budget coverage to avoid double funding of one activity. At times CCP will advocate for providing some financial support when requested, to build relationship with DPS over the long term.

5.9 *Activista* turnover

Challenge: *Activistas*, who are the cornerstone of community based services, sometimes drop out of service, for various reasons. Some find formal employment or other better opportunities, some move away, some become ill themselves, etc.
To overcome: CCP will capitalize on the province level, and sometimes district level, cadre of accredited HBC/OVC trainers to train replacement *activistas*, when newly recruited by the funded CSO.

5.10 CSO capacity

Challenge: CSOs capacity varies widely, even with past experience with international or national donors.
To overcome: CCP FHI 360 will deploy specific sub-agreement officers to those CSOs needing extra mentoring to improve knowledge and practice on compliance and other management activities to best complement the CAP capacity building strategy.

5.11 Nutrition

Challenge: CCP has linked with UNICEF for child MUAC tapes but has so far been unable to locate a source for adult MUACs.
To overcome: CCP would ask USAID if they are aware of any sources for the project to avail; check with FANTA since the Nutrition Department has been out of stock.

5.12 CCP Workplan

Challenge: Some activities in original project workplans seem less relevant now that the project is actively implementing.
To overcome: Discuss with COR the possibility of deleting such identified activities from the Yr 3 and future annual workplans, assuring to follow the contract.

5.13 Exclusive Branding

Challenge: National staff at central and provincial levels uncomfortable with placing GOM logo at bottom of items rather than at the top.
To overcome: Discuss with COR on possibility of renegotiating placement of logos, in the context of exclusive branding, given that CCP is a contract.

6. Program and Operational Management

6.1 Baseline Survey

In this reporting period, PCC continues to follow-up with GSC to deliver the final baseline report. Delays in providing the final report are due to unanticipated health issues by the contractor. Scheduled meetings and promised report submission do not materialize, continued attempts to communicate are not responded to. The most recent extension to the contract with GSC will expire on 31 July 2012. FHI 360 headquarters staff will be able to take on the report writing task at that point in time.

Launching of the new project name – USAID Programa de Cuidados Comunitários – was accomplished in this reporting period at national, provincial, and district levels, when it was clear that combining the new name with baseline dissemination was not feasible.

6.2 Project Renaming

The CCP team accomplished awareness raising in this reporting period on the project name change, through formal communications to government structures as well as providing project banners to each CSO. At district level, each CSO will use the banners during trainings, community activities, stakeholder meetings and any other opportunities.

6.3 Sub-Contracts and Consultancies

- The gender mainstreaming strategy consultancy with Ernst & Young staff concluded this reporting period. See the strategy in Annex A10, which will commence activities during the next quarter (August) with identifying gender focal points at project provincial level. The Year 3 Annual Workplan meeting in August will serve as a key dissemination point for the gender strategy, with clear roll-out of roles and responsibilities.

- The REPSSI ToT consultancy to train trainers in providing psychosocial support to OVC and their families was finalized in this reporting period. The training schedule commences in August and carries through October 2012. The opportunity to strengthen this particular social service network is profound. The CCP model is to train each target district SDSMAS OVC or Social Action focal point, and, the funded CSO supervisor, in PSS. They will in turn, as a team of two in each district, train the CSO *activistas* in providing PSS. CCP has reached out to other OVC projects in other provinces to include them in these trainings where feasible.

  When all these trainings have taken place, the next step of providing PSS to the CPCCs will be explored in Yr 3, as well as using the new cadre of trainers to collaboratively

determine with *activistas* how best to apply PSS to their own needs as community caregivers.

- The Project HOPE economic strengthening CSO for Niassa Province, ROADS (not to be confused with the FHI 360 project ROADS), was finalized this quarter. At the time of this report, the remaining CSO to cover this project component in Tete Province, ADELT, was still awaiting USAID approval pending completion of a new requirement to the approval process.

- GUCs for CSOs in three more districts were finalized this quarter, for Mutarara (in Tete), Ngauma (Niassa), and Muanza (Sofala). Gorongosa district remains pending, with the CSO in GUC approval processes.

- With the new mission requirement of Negotiation Memos for each GUC, FHI 360 in this quarter was able to respond quickly with identifying regional technical assistance for this task, to commence early next quarter in July. This TA will work with FHI 360 CCP project staff, as well as the consortium partners, to construct the Negotiation Memos for USAID approval.

- FHI 360 will carry out a Technical Quality Assessment (TQA) of CCP, sampling from Sofala and Niassa Provinces, for two weeks in the first half of the next quarter. The TQA is timely, in that the project's Year 3 Workplan can include and benefit from TQA inputs and recommendations.

- A combination of mechanisms was finalized during this reporting period regarding CSO Capacity Building. Negotiations with CAP were finalized, to cover four CSOs in each of three provinces, to receive their full package of training, coaching, etc. The public tender for the consultancy to provide geographically complementary CSO capacity building activities was formulated for release early in the next quarter.

- The Yr 3 Workplan workshop with take place 13-17 August, in preparation for 31 August 2012 submission to USAID, per CCP contract. FHI 360 Regional Technical Advisor, Carla Horne, will provide on-site TA. Her ongoing engagement with CCP is a bonus to the project, eliminating need for one-off consultants to provide this type of TA.

6.4 Organizational Structure and Personnel

- The replacement World Relief (WR) Inhambane Provincial Coordinator was identified this quarter. Interim coverage was ably provided by the WR country director and the M&E officer.
- Interviews for the replacement Africare Manica Provincial Coordinator took place. The vacancy had been very well covered between the Africare country director and their on-site interim coordinator.
- The Project HOPE replacement Finance Manager interviews were taking place and promising.
- The new FHI 360 Country Director has been identified and will be in-country in early August 2012.

7. Financial Summary

CCP expended $6,637,248 by the end of Yr2 Q3, achieving a 66% burn rate, against the Yr 2 budget which included savings from Yr1. Consortium partners Yr2 Q3 burn rates were Africare 83%, Project HOPE 75%, and World Relief 63%. The project fully intends to utilize the balance of Yr2 funds during the final quarter, on such activities as PSS ToT, followed by training of CSO's *activistas*; resupplying of HBC nurse/supervisor kits, new *activista* kits, and the periodic refill kits for both levels; materials to support the integrated caregiver such as respirator masks to wear when making the family visits, boots, other caregiver protective products; IEC materials for supporting OVC implementation; other trainings or refresher trainings per needs of new caregivers or the periodic refresher timeline; production of the Referral/Counter-Referral tool for total district coverage; various TA supports; the initial CSO Capacity Building trainings; CCP IEC materials for the FHI 360 booth at the MISAU Jornadas conference in September.

Funding these specific activities complements the month-to-month funds transfers to the sub-contractors and GUC holders who implement PCC, as well as the continuous Maputo- and province-based technical assistance.

8. Plan for Next Quarter

July 2012
Monthly Technical Meeting
Draft Negotiation Memos for all GUCs processed and approved
Present OVC situation and CCP activities to new Peace Corps Volunteers training group
Continuous TA
Conclude DQA reports
Yr2 Q3 report development and submission

August
REPSSI ToTs on psychosocial support for Maputo, Inhambane, and Sofala Provinces
Activista trainings on psychosocial support in Maputo, Inhambane, and Sofala Provinces
Monthly Technical Meeting
FHI 360 TQA in Sofala and Niassa Provinces, 2 weeks
Yr 3 Workplan Workshop, and submission
Quarterly Management Meeting
CSO Capacity Building training begins with Maputo Province CSOs
VS&L commences in Tete if CSO (ADELT) is approved by USAID
TA and Supportive Supervision
Distribution of and training on Referral/Counter-Referral tool

September
Monthly Technical Meeting
CSOs Annual GUC Amendments
Participate in FHI 360 information booth at Jornadas, Maputo